Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING
May 25, 2017
Elihu M. Harris State Building
Oakland, California

In Attendance
Acting Chair, Martin Brady
Commissioners Doug Bloch, Christy Bouma, Mona Garfias, Angie Wei

Absent
2017 Chair Daniel Bagan, Shelley Kessler, Sean McNally

At-a-Glance Summary of Voted Decisions from the CHSWC Meeting*

Approval of minutes from the last meeting	**Approved**
Posting of DRAFT report titled "Evaluation of SB 863 Medical Care Reforms," by Andrew Mulcahy and Barbara Wynn at RAND, for feedback and comment after it is available, with final posting after 30 days	**Approved**
Return to Work Fund Request for Proposal	**Approved**
Proposal to develop a training module to comply with AB 1978, which includes development of a training program for janitorial workers in English and Spanish jointly funded by the Department of Industrial Relations and CHSWC	**Approved**
Direct staff to respond to Assembly member Timothy Grayson's request to gather data and conduct a study on first responder occupational behavioral health	**Approved**

Approval of Minutes from the March 24, 2017, CHSWC Meeting

CHSWC Vote

Commissioner Bouma moved to approve the minutes of the March 24, 2017, meeting, and Commissioner Garfias seconded. The motion passed unanimously.

Commissioner Brady welcomed Mona Garfias to the Commission. She was appointed by the Senate Rule Committee as an employer representative and has been director of claims for DMS Facility Services, a large unionized employer in the janitorial industry.

* *Note:* These minutes are abbreviated because of technical difficulties with the recording devices.

DWC Updates

George Parisotto, Acting Administrative Director, Division of Workers' Compensation (DWC)

Anti-Fraud Measures

- Automatic Stay of Liens
  - Labor Code section 4615 allows DWC to stay the liens of physicians or providers who are criminally charged with workers' compensation fraud, medical billing fraud, insurance fraud, and Medicare or Medi-Cal fraud automatically stayed, pending the disposition of criminal case.
  - 121 criminally charged providers
  - 285,000 liens currently stayed

- Suspension of Providers
  - DWC can suspend any provider who has been convicted of a felony or misdemeanor that involves fraud or abuse of Medi-Cal, Medicare, or the workers' compensation system or fraud or abuse of a patient; who has had a license revoked or suspended; who has been suspended, because of fraud or abuse, from Medicare or Medicaid programs
  - 25 providers have been suspended.
  - 5 notices of suspension sent out per week.

- Lien Consolidation Proceedings
  - If the disposition of the criminal proceedings provides for the liens to be dismissed, they will be dismissed with prejudice by operation of law.
  - If the disposition of the criminal proceedings does not address the disposition of the liens pending in the workers' compensation system, the liens will be identified, consolidated, and subjected to special lien adjudication proceedings.
  - One consolidation hearing has been held; several more are waiting to be scheduled.

Formulary

- A hearing on the proposed formulary was held on May 1. DWC is now evaluating comments.
- At the request of most stakeholders, DWC is considering delaying implementation until January 1, 2018.
- Also considering revisions to the preferred drug list and the ground rules regarding utilization review (UR)
- The first 15-day comment period will probably be held in two weeks.

Updates to the Medical Treatment Utilization Schedule (MTUS) Treatment Guidelines

Guidelines are projected to be updated, with new chapters in place, by the end of 2017 to align with the adoption of the formulary, and the rulemaking process is expected to begin next month.

- Updates to current MTUS topics:
  - General approaches
  - Neck and upper back
  - Shoulder
  - Elbow
  - Forearm, wrist, and hand
  - Low back
  - Knee
  - Ankle and foot
  - Stress (mental health)
  - Eye
  - Chronic pain
  - Opioids

New Treatment Guidelines

- New topics to be added:
  - Hip and groin
  - Interstitial lung disease
  - Occupational asthma
  - Traumatic brain injury

Other Regulations

Working to put SB 1160 regulations in place

- Collection of UR data
- Limited UR within first 30 days of Date of Injury (DOI)
- UR process changes
- Electronic medical reporting

Independent Medical Review (IMR)

- Numbers have stayed relatively constant
  - April: 19,771 applications
    - 15,403 unique applications
    - 14,047 eligible applications

- System is working in a timely fashion:
  - Decisions issued 30 days from the date medical records are requested and 10-12 days after receipt of the records
  - Efforts to allow electronic submission of records in addition to the Division's efforts to penalize claims administrators have been effective at achieving timely results
  - Decisions: (12,968) 87% of UR is upheld, and 13% is overturned and denied

Anti-Fraud Report
Nick Pace, RAND

Provider Fraud in California Workers' Compensation: Selected Issues

RAND Uses the Term Fraud Expansively

- *Fraud* consists of making a knowingly false or fraudulent material statement or representation for the purpose of deceiving others, which often constitutes a criminal offense
- We include fraudulent acts that may not meet the requirements for criminal sanctions, if made for material gain or for negatively affecting others' rights
- We also include *abuse*, behavior that is deficient or improper, compared to what a prudent person would consider a reasonable and necessary practice
  - Misuse of authority/position for personal gain
  - Intentional violations of the law

Key Categories of Fraud in Workers' Comp

- Provider fraud (e.g., ordering tests that are known to be unnecessary)
- Employer fraud (e.g., misclassifying employees to obtain lower premiums)
- Employee fraud (e.g., failing to report earned wages while receiving temporary disability benefits)
- Attorney fraud (e.g., receiving kickbacks for sending clients to certain health-care providers)
- Insurer fraud (e.g., delaying payments in bad faith)
- Claims adjuster fraud (e.g., falsifying documents to justify denying claims)

RAND Was Asked to Look at Provider Fraud and Focused on Specific Approaches to Address It

- *Prevention.* Creating barriers to prevent fraudulent behavior from taking place or being profitable
- *Detection.* Identifying those who have acted fraudulently or who are currently committing fraud

- *Remediation.* Taking steps to stop continuing fraudulent behavior or profiting from past activities
- *Restitution.* Helping to restore victims to their pre-fraud condition
- *Retribution.* Achieving a sense of justice for both victims and the public at large
- *Deterrence.* Transmitting signals that fraud is not worth the potential detection or punishment

RAND Explored Advanced Analytics, Postemployment Claims, and Lien Filing by Suspected Fraudsters

Advanced Analytics Offers Great Promise

- A field of information science that involves intensive examination of large volumes of data in order to discover relationships across records
- Other social welfare programs have had generally favorable results using these techniques to identify those engaging in fraud
- But the current state of California workers' compensation data might hinder realization of the method's full potential
  - Shortcomings in how records are collected and accessed
  - Important information is often in siloes

Postemployment Claims & Cost Controls

- Employers must furnish up to $10k for treatment after the claim is filed, which can limit provider selection during this time
  - But after a claim is rejected, employees can get their own providers who will seek reimbursement on a lien basis
- Postemployment claims typically involve cumulative trauma and are highly likely to be denied quickly
  - Liens are larger than average, highly concentrated in certain areas and from certain providers, and routinely settle for just 10% of claimed value
- Lien volume and value in denied postemployment claims would be reduced if employers had continuing control over care with more direct Official Medical Fee Schedule (OMFS) and UR oversight

Lien Filing by Suspected Fraudsters

- Nearly a fifth of liens are filed by providers who are under indictment or have been convicted
- New laws (Labor Code Sections 4615 and 139.21) offer the means to stay liens or suspend providers but either require formal prosecution or affect only a narrow set of liens
- A Medicaid policy suspends payments when a credible fraud allegation is under investigation
  - Applies to providers who are only under suspicion

- Covers all requests for payment, regardless of whether they are related to original fraud allegations
- Payment stay ends after investigation or criminal proceedings are concluded

Recommendations

Identification: Take steps now to incorporate the use of data analytics into DIR's routine fraud-detection work
Prevention: Give employers the option of denying a questionable postemployment claim while continuing to offer medical care under their control
Remediation: Use Medicaid suspension policy as a tool in addition to LC Sections 4615 and 139.21 to take active fraudsters out of the workers' compensation system
Global: Implement a centralized and permanent workers' compensation fraud data unit to enhance opportunities for detecting and addressing fraud

Commissioners' comments:

One comment by the Commissioners relates to post-employment claims. Mr. Pace said that one employer tactic is denying and forcing injured workers to go outside the [MPN] network. He said that, strategically, it might be a better idea to accept treating them in order to maintain medical control but not immediately accepting Arising Out of Employment/Course of Employment (AOE/COE) (i.e., immediately accepting it as an occupational injury).

Commissioner Bloch expressed interest in a different kind of fraud, that of independent contractors and misclassification. There was some consternation that the study focused only on provider fraud, but that was the agreed and approved scope of the contract with RAND.

Greg Webber of Med Legal asked about the data used in the study. Mr. Pace explained that the study did not access specific data but mentioned potential difficulties in accessing data housed in siloed locations.

Evaluation of SB 863 Medical Care Reforms
Barbara Wynn and Andrew Mulcahy, RAND

Barbara Wynn and Andrew Mulcahy presented an Evaluation of SB 863 Medical Care Reforms. The purpose of the presentation was to summarize findings and recommendations from RAND's evaluation of SB 863 and describe the overall impact of SB 863 on health care and work-related outcomes for medical-legal services trends and issues and workers' compensation-required reports.

SB 863 Medical Provisions Were Implemented at Different Times:

- January 2013: IMR (new injuries), IBR reforms
  Separate payments for spinal hardware reduced
  Ambulatory Service Center (ASC) facility fees reduced
- July 2013: IMR reforms (all other injuries)

- September 2013: Changes to Qualified Medical Examiner (QME) panels
- January 2014: Adoption of Resource-Based Relative Value Scale (RBRVS) (year 1 of a four-year transition)
  Separate payments for spinal hardware eliminated

The study evaluated impacts on health care and work-related outcomes relative to comparison groups:

- Health-care utilization and spending outcomes were determined using a 12-month utilization (bill lines) and spending for specific conditions. The source of bias in pre/post comparisons was changes in medical practice and technology. "Pre" is 12-month spending for 2012 injuries. "Post" is 12-month spending for 2014 injuries. The comparison group for the health-care utilization and spending was privately insured patients with the same specific market conditions (Marketscan). The time horizon used was the 2012-2014 injuries.

- The work-related outcomes were determined using wages and employment data. The source of bias in pre/post comparisons was changing (generally improving) economic conditions. The comparison group was non-injured California employees (data from the Employment Development Department). The data used was 2010 through 2014 injuries.

The study concluded that it did not find reductions in workers' comp medical spending compared to the comparison group:

- The pre/post difference for injured workers—$160, or 6%—is statistically significant.
- So is the pre/post difference for the comparison group ($163 or 8%).
- The difference-in-difference (DD) estimate is not statistically distinguishable from zero.
- Notes: Spending is for bill lines with a diagnosis code matching one of the 66 Clinical Classification Software (CCS) diagnosis groups or pair of groups in the 2011 Workers' Compensation Information System (WCIS) data more than 1,000 times. Comparison patients were matched to injured workers using a propensity score approach. Both pre- and post- differences are significant at $p < 0.001$.

Other health-care utilization and spending findings:

- We found statistically significant but small (< $50/year) changes in spending for injured workers relative to controls in some categories of medical care.
- Health-care utilization decreased slightly for both injured workers (by 3.5%) and comparison patients (by 6.6%)
- Notes: Service categories with statistically significant ($p < 0.05$) DD estimates included inpatient other than inpatient hospital ($22) and prosthetics/orthotics ($4), in which spending for comparison patients increased relative to injured workers over the SB 863 implementation period and anesthesia (-$3), drugs (-$3), evaluation and management (-$11), medicine (-$18), radiology (-$4), and surgery (-$10), in which spending decreased for injured workers relative to comparison patients.

Prior studies showed reductions in earnings for injured workers compared to non-injured control workers.

Earnings and employment did not change significantly for pre and post-SB 863 injuries

Injured worker outcome relative to matched controls	Injury Year		
	2010-2012	2013	2014
Earnings	90.6%	90.7%	91.0%
Employment	94.7%	96.0%	96.3%
At-Injury Employment	86.7%	86.6%	85.7%

Percentages are the ratio of the outcome for injured workers relative to control workers.

SB 863 Promoted Efficient Delivery of Medically Appropriate Care:

- IMR reinforces the use of evidence-based medicine in care decisions and streamlines the medical necessity dispute resolution process
- RBRVS improves incentives for furnishing medically appropriate care by aligning physician payment with resources required to deliver services
- Revised OMFS fee schedules for inpatient and ASC facility fees eliminate unnecessary allowances

DIR Asked RAND to Review Other Policies in Light of the SB 863 Changes

Focus areas

- Medical-legal fee schedule
- Workers' comp-required reports

Study approach

- Stakeholder interviews and consultation with a technical advisory group
- Review of other state workers' comp program practices
- Analysis of WCIS medical data
- Comparison of fee schedule allowances to RBRVS allowances for similar activities

Medical-Legal (ML) Fee Schedule

- Three levels of initial evaluations
  - ML 102 Basic comprehensive: $625 (2.5 hours assumed)
  - ML 103 Complex comprehensive: $ 938 (3.75 hours assumed)
  - ML 104 Comprehensive evaluation involving extraordinary circumstances ($250 hourly rate)
- Complicated criteria used to determine the evaluation level
  - Time spent with patient and on research and medical record review
  - Whether causation or apportionment was considered
  - Whether psychiatric/psychological evaluation involved
- Fee schedule has not been revised since 2007

Medical-Legal Fee Schedule: Findings

WCIS aggregate spending for medical-legal expenses increased 46% from 2007 to 2012
- Proportion of ML 104 time-based initial evaluations increased from 44% to 54% of initial evaluations
- Average number of units billed per ML 104 evaluation increased 47% (3.5-hour increase in reported time for the evaluation)
- Ratio of follow-up evaluations to initial evaluations increased 30%

- The $250 hourly rate is higher than RBRVS allowances for comparable activities
- Payers are frustrated by the quality of reports and need for follow-up reports
- Providers believe fees are insufficient and note the administrative burden of cancellations and medical record review

States Have Different Practices for ML Evaluations

- 22 states use a fee schedule to pay for evaluations
  - 13 states use an hourly rate ($200-$600)
    - May have higher rate for first hour
    - May have different rate for medical record review
    - May cap the number of hours
  - 9 states use a flat rate (most vary by type of issues and/or body parts)
- Several states pay a cancellation fee
- Several states have penalties related to medical records
  - Untimely submission
  - Unorganized

Medical-Legal Fee Schedule Recommendations

Consideration should be given to:
- Converting the ML 104 allowance into a flat rate that varies based on case complexity
- Payment incentives for high-quality reports that do not require a follow-up report
- Policies that facilitate a more efficient evaluation process
  - Cancellation fees
  - Timely receipt of medical documentation

Limitations:
- Did not examine quality of reports
- Data did not allow assessment of potentially abusive billing practices

Reports Required by Workers' Comp: Doctor's First Report of Injury (DFR)

- Doctor's First Report
  - Filed by each treating physician
  - No allowance is made for the report
  - SB 1160 requires electronic filing

- Findings
  - Confusion regarding when the report is required (any physician or only primary treating physician)
  - Multiple reports from different physicians do not add value

- Mixed findings regarding whether lack of payment is problematic
  - 120% multiplier vs. allowance for progress reports

DFR Recommendations

- Require DFR only from the first primary treating physician and, if applicable, the first physician to treat the injury
- Establish an allowance comparable to the allowance for physician progress reports
- Use the allowance as an incentive for timely electronic reporting
- Estimated cost: $8 million-$20 million depending on allowance for physician progress reports

Progress Reports (PR-2) and Requests for Authorization (RFAs):

- Progress Reports
  - Required at least every 45 days or if the patient's condition or treatment plan changes
  - Addresses medical progress and changes in treatment plan, incorporates reports from secondary physicians, assesses functional capacity and ability to return to work
  - Separate allowance continued under RBRVS (currently $12.29)
- RFAs
  - Written request documenting medical necessity
  - Required when seeking prospective authorization
  - PR-2, DFR, or comparable form must be filed with RFA
  - No separate OMFS allowance

Progress Report and RFA: Findings

- Some payers accept PR-2s from any treating physician and others accept only from primary treating physicians (PTPs)
- PTPs report that obtaining and consolidating reports from secondary physicians is time consuming and delays reports
- Payers express concern that some reports are not timely and often do not document patient's medical progress or treatment goals
- Relative to similar services paid under the RBRVS, the allowance for PR-2s is undervalued ($30 vs. $12.29)

Progress Reports and RFAs: Recommendations

- Reduce administrative burden
  - Consolidate the PR-2 and RFA into a single form
  - Consider mandatory electronic reporting
  - Develop an abbreviated combined PR-2/RFA for secondary physicians to file directly with the claims administrator with a copy to the primary treating physician (PTP)
  - Make the allowance for a fully completed PR-2 more in-line with RBRVS allowances for similar services (approximately $30 per report)
    - Estimated cost: up to $30 million if paid for all PR-2 reports

- Use higher payment as an incentive for timely filing of complete reports

Permanent and Stationary (P&S) and Return to Work (RTW) Reports

- P&S report
  - Used by PTP to report the initial evaluation of permanent impairment to the claims administrator
  - Addresses impairment rating, apportionment, causation, functional capacity, and future medical treatment.
  - Separately payable rate per page with maximum number of pages
  - The examination is separately paid as an Evaluation & Management (E&M) visit.
- RTW and voucher report
  - Used to inform the employer of the work capacities and activity restrictions resulting from the injury
  - Must be filed with the P&S report

P&S and RTW and Voucher Reports: Findings

- Payers concerned with the completeness and quality of the reports
- Providers believe the reports are undervalued
- Adequacy of additional allowance ($93) for filing a report depends on what it is intended to cover
  - Likely to be sufficient for completing the report and determining the impairment rating
  - Undervalued if it also includes time for review of medical records
- Redundancies between functional capability information P&S and RTW reports

P&S and RTW and Voucher Reports: Recommendations

- Consider restructuring the P&S allowance
- Establish a combined allowance for the P&S evaluation, any related services such as medical review and the report that accounts for differences in case complexity.
- Use findings from an evaluation of the medical-legal fee schedule to determine a reasonable allowance for the PTP's impairment examination and report
  - Use higher payment as incentive for timely and high-quality reporting
  - Eliminate the redundancies between the P&S report and the RTW report
- Explore giving the PTP the option of not evaluating the impairment

SB 863 Provisions Reflect Continuous Efforts to Improve the Quality and Efficiency of WC Program

/2004:	MTUS and UR provisions
• SB 899	Medical provider networks (MPNs)
• AB227/SB228	Medicare-based fee schedule for most services
/2014:	IMR and IBR, RBRVS
• SB 863	Fee schedule revisions for pharmacy, inpatient, and ASC services
	Improve MPN accountability

5/2016: Drug formulary

- AB 1124, AB 1160, AB 1244 — Improve process for UR/IMR, DWC oversight, medical liens, fraud

  - Ongoing monitoring of system performance facilitated by improving WCIS reporting compliance
  - Challenge is to create program safeguards to curb abuses without imposing additional burden on providers

Public comments:

Rick Meecham from the California Applicant Attorneys Association stated that he would like to have the data for review before the meeting. Also, combining PTP forms should be pursued. They should also have metrics for better outcomes. According to Mr. Meecham, 90% of workers' return to work outcomes are not good.

CHSWC Report

Eduardo Enz, Executive Officer, CHSWC

Mr. Enz stated:

- CHSWC staff has prepared a Request for Proposal (RFP) to conduct a study on the RTW benefit. Approval of the RTW benefit RFP is an action item today.
- CHSWC staff have been actively engaged in organizing and participating in a variety of activities, including the annual Safe Jobs for Youth Month information campaign in May.

  - The objective of the Safe Jobs for Youth campaign is to educate youth and inform employers, parents, and the community about workplace health and safety to prevent workplace injuries among teens.

  - The campaign is designed to help better prepare youth as they seek summer employment opportunities.

  - On May 16, CHSWC staff, together with personnel from our three partner training centers at UC Berkeley, UCLA, and UC Davis, held our annual Worker Occupational Safety and Health Training and. Education Program (WOSHTEP) Advisory Board Meeting in Oakland. The purpose of this advisory board meeting is to provide an overview and updates to the board and receive their guidance on potential new directions for the WOSHTEP program.

There are four action items for your consideration today.

1. Does the Commission wish to post for feedback and comment after it is available and for final posting 30 days thereafter the DRAFT report titled "Evaluation of SB 863 Medical Care Reforms," by Andrew Mulcahy and Barbara Wynn at RAND?

- All approved

2. Does the Commission wish to approve the DRAFT Return to Work Fund Request for Proposal?

    - All approved

3. Does the Commission wish to approve a proposal to develop a training module to comply with AB 1978, which includes development of a training program for janitorial workers in English and Spanish jointly funded by the Department of Industrial Relations and CHSWC?

    - All approved

Legislative request from Assembly member Tim Grayson

- Requested that CHSWC gather data and conduct a study on first responder occupational behavioral health and focus on post-traumatic stress disorder (PTSD) and comparison of the behavioral health of public and non-public safety occupations.

Does the Commission wish to direct staff to respond to Assembly member Timothy Grayson's request to gather data and conduct a study on first responder occupational behavioral health?

- All approved

Other Business

None.

Adjournment

The meeting was adjourned at 12:15 p.m.

Approved:

Daniel Bagan, Chair — Date: 10/19/17

Respectfully submitted:

Eduardo Enz, Executive Officer, CHSWC — Date: 10/19/17